State of Illinois
Department of Human Services - Bureau of Child Care and Development

WAGE VERIFICATION

I hereby authorize my employer to release the following information to the Illinois Department of Human Services. I understand that this information may be verified by phone. Any fraudulent, false or misleading information given may result in loss of childcare payments and my child care case may be cancelled or denied.

Client Signature

Client Case Number

Date

JOB INFORMATION: TO BE COMPLETED BY YOUR EMPLOYER ONLY.

Employee Name: _____ Start Date: _____

Rate of Hourly Pay: _____ Commission: _____ Tips: _____ (Monthly Average)

Pay Period: Weekly: _____ Bi-Weekly: _____ Twice Per Month: _____ Monthly: _____

Is the employee paid cash? ☐ Yes ☐ No Employee Job Title: _____

If on leave: Return Date: _____ Type of Leave: _____

WORK SCHEDULE: If your schedule varies, provide an example of your schedule.

	MON	TUES	WED	THURS	FRI	SAT	SUN
FROM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
TO	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

Do these hours vary? _____ If yes, please explain: _____

Employer / Company Name: _____

Employer Address: _____ City: _____

Employer Phone Number: _____

Employer Name Printed

Title

Employer Signature

Date

THIS FORM MUST BE COMPLETED BY YOUR EMPLOYER AND RETURNED TO THE ADDRESS AT THE RIGHT WITHIN 10 BUSINESS DAYS.

PLEASE RETURN FORM TO:

Illinois Action For Children
1340 South Damen Avenue, 3rd Floor
Chicago, IL 60608